REQUEST for STAKEHOLDER COMMENT
Design and Development of an Insurance Exchange in Connecticut

The following information is organized by general topic area, with a list of questions we would like you/your organization to answer as you feel appropriate. These questions are followed by background briefings to provide a general understanding of the topics. To encourage productive discussion during each meeting, we are providing you this information in advance of your meeting. While these topic areas are the specific issues for which public comment is requested, please feel free to offer any other comments on policies related to the Exchange and the insurance market as well.

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QUESTIONS

Please provide us with your thoughts and insights on the questions listed below as you feel appropriate.

A. Establish a Responsive and Efficient Structure

1. Should Connecticut consider joining a multi-state Exchange? Under a regional Exchange, would Connecticut benefit most from a separate or merged risk pool?

   Connecticut should not join a multi-state exchange. CSMS has consistently expressed the position that Connecticut should develop its own exchange, unique and understanding of the needs of its citizen, with existing protections that are available to the patients of Connecticut and the process and administrative protections afforded to physicians and other health care professional.

2. Should Connecticut administer the Exchanges for the individual and small group markets separately or jointly? If jointly, should Connecticut maintain separate risk pools for the two Exchanges, or merge the risk pools.

   Connecticut should administer the exchanges jointly with one merged risk pool to allow for more simplicity of choice and explanation while achieving some efficiencies that are associated with economies of scale.

3. Should Connecticut open the Exchange to businesses with 2-100 employees in 2014, or should it allow businesses with 2-50 employees in 2014 and increase participation to businesses with 51-100 employees in 2016?

   If at all possible, the exchange should be open to businesses with 2-100 employees in 2014. This would allow greater access to the exchange, especially in a state that has a much higher

than average health insurance premium than the rest of the country for small group (employer) plans.

4. Should Connecticut seek to expand access to businesses with more than 100 employees in 2017, with HHS approval?
   Yes, as it would likely result in some economies of scale that could be used to further reduce costs for those purchasing insurance through the exchange.

B. Address Adverse Selection and the External Market

1. Should Connecticut allow a dual market, a hybrid market, or should it require that all individual insurance be sold through the Exchange? Under a dual market scenario, what additional rules should Connecticut establish to prevent insurers from discouraging participation in the Exchange? What hybrid models might Connecticut consider, and what characteristics do they offer that would benefit Connecticut?
   All individual plans should be sold through the exchange so that the citizens of Connecticut can compare and contrast what is available to them and information could be clearly and accurately presented about the plan options.

2. Are there any additional mechanisms to mitigate adverse selection that Connecticut should consider implementing as part of the Exchange?
   Many have said that the single most important reason why some exchanges have not succeeded in the past is that they became the victims of adverse selection and they simply were unable to capture a large enough share of the healthy participants in the insurance market to override the risk (they became large high risk pools). The exchange, though this sounds counter intuitive, needs to be careful not to offer better coverage, or more affordable coverage, to too many individuals or groups with unfavorable risk profiles and were unable to attract enough healthy enrollees.

   The PPACA includes some provisions that weaken incentives for adverse selection. However, adverse selection is still a possibility because the PPACA allows both an individual and group health insurance market to continue to exist outside the exchange to encourage continuation of the existing health insurance market.

   Steps that the state may need to take to further reduce adverse selection include: prohibit insurers that participate in the exchange from establishing separate affiliates to sell only outside the exchange; prohibit insurers from selling only low level (sometimes referred to as "bronze plans") or catastrophic coverage outside the exchange; or prohibit insurers from using marketing practices or benefit structures intended to attract healthy applicants to plans outside the exchange while discouraging unhealthy applicants. All of these actions will require specific monitoring not only of the exchange, but the health insurance market as a hole, requiring the state regulatory agency to act more like a policing agency. In addition, the state regulator can monitor grandfathered plans carefully to make sure that they are not 'lemon dropping'—or rather encouraging high-cost enrollees to move to the exchange – this is often done by providing those specific patients with information on their options, stressing that more coverage or care could be provided in other plans that are available through the exchange (again, by helping the individual patient by providing information and even advice tied to participating in the exchange, the exchange could become a high risk pool).

   The other possible approach is to prohibit brokers from collecting higher commissions for plans sold outside the exchange, thereby discouraging them from steering business elsewhere, but brokerage fees are generally contractual negotiations between the plans and the brokers and fees do sometimes vary across plan types and insurers, based on the level of education, information and sophistication in marketing and selling the plans, as well as educating the

employer and consumer (and setting up the plans for the employer and monitoring the plan usage by employees).

3. How should the temporary reinsurance program be approached in Connecticut? What issues should Connecticut be aware of in establishing these mechanisms?

C. Simplify Health Insurance Purchase

1. What issues should Connecticut consider in establishing a Navigator program?
    a. ***Ease of access to the program***
    b. ***Clarity of communications***
    c. ***Cultural diversity within the state***
    d. ***Cultural diversity of the physician and health care professionals providing medical care in this state (note that CSMS launched two years ago, with funding primarily from the Connecticut Health Foundation and the CSMS Physician Health and Education Fund, a program called "Care in Context" whereby CSMS has been educating physicians about health care disparities in an effort to further health equity within the State of Connecticut. More needs to be done in this area as there are significant gaps in education of both physicians and patients and information available for patients in their native languages.***
    e. ***Public Transportation (or lack thereof)***
    f. ***Where care is provided in this state (geographic barriers to care)***
    g. ***How patients are presently educated- health literacy issues***
    h. ***Use of marketing and communication (again, CSMS CIC program has moved forward in providing physicians with information for their patients on access to care issues).***

2. What should Connecticut consider regarding the role of insurance brokers and agents?
That they commit to serving as partners with the exchange and in many ways, the front line educators for the exchange, working with the exchange, the physicians and the health care professionals and the employers. It has been, traditionally in Connecticut, in the small group markets, the brokers who have provided the level of education and information necessary in making informed decisions and choices on health care insurance decisions (selection).

D. Increase Access to and Portability of High Quality Health Insurance

1. Should Connecticut allow any plan that meets Qualified Health Plan standards to be available in the Exchange, or should Connecticut establish additional requirements? If additional requirements, what would you recommend? What would be impact of those requirements?
Allowing and QHP to be available within the exchange would allow for greater choice. However, the Navigator will need to provide concise information outlining benefits and differentiating between plans- in ways that consumers will understand.

2. Should Connecticut consider establishing the Basic Health Program? What would the Basic Health Program offer as a tool to facilitate continuity of coverage and care?
There may be a way to take what Connecticut tried to create tied to the Charter Oak program and transform or transition it into a Basic Health Program as outlined by PPACA, but the issue of administration of that plan and whether or how it would be rolled up into the exchange would have to be discussed further as it could become a high risk pool if not administered correctly (and certain benefits afforded and others excluded)

3. How would the Basic Health Program impact other related programs in Connecticut?
The BHP should not preempt other programs in the state. Programs such as the HUSKY plan and other state programs must continue to provide benefits and coverage that has been determined appropriate to meet the needs of the constituents they serve and afford patients and

physicians and other health care providers and professionals with the necessary protections that Connecticut has established.

4. How can Connecticut structure its Exchanges to maximize continuity of coverage and seamless transition between public and private coverage? (E.g. as a person moves from Medicaid, subsidized and non-subsidized markets)
   Through plan portability as well as a seamless transfer of any paid or earned premium and a fluid exchange of information between the various state agencies involved in not only the exchange, but Husky/Charter Oak/SAGA and other state programs and services (behavioral health programs included).

E. Ensure Greater Accountability and Transparency

1. What information should Connecticut include for outreach to most effectively engage consumers? How should the information be presented?
   Answers to this question is probably best developed through discussion of the exchange boar, once more is known about the direction that the board and the exchange are going to take as to what plans and options will be available. At a minimum it should include any current statutory requirements.

2. How should Connecticut ensure ongoing feedback and input about accountability, operational issues, and suggested improvements?
   Online, through brokers, and public forums as well as through interaction and discussion with the physicians and other health care professionals and providers who are providing medical care tied to the exchange plans.

3. What information, beyond that required under the ACA and implementing regulations, should Connecticut require of plans? How much of this information should be shared with consumers accessing the Exchange?
   This should be determined by the exchange on an ongoing basis but must include all actuarial data and when possible ALL should be shared with consumer and physicians and other health care professionals providing care through exchange plans or plan options. Information and how it is going to be shared and used will be the key to success of the exchange in the short term and long term.

F. Self-Sustaining Financing

1. How should the Exchange's operations be financed beginning in 2015?
   Participating Plan Surcharge

2. How might the state's financing strategies encourage or discourage participation in the Exchange; affect the reputation of the Exchange; and affect accountability, transparency, and cost-effectiveness?
   A well funded exchange will help make sure that access to high quality and comprehensive information is not delayed. Regardless of financing strategies, proper structure of the Exchange Board will maintain its reputation, accountability, transparency and cost-effectiveness.

3. What issues should be considered regarding state requirements for additional benefits above the minimum essential benefits? What funding sources should be considered for the cost of additional benefits?
   The needs of Connecticut residents are complex and vary among populations, communities and programs. The Exchange Board will need to address this issue and understand the geographic specificity and limitations of where medical care is provided in Connecticut, and also how it is provided. There are some existing state regulations that may need to be changed to allow for greater access to ambulatory medical care.

G. Under the ACA, an Exchange is responsible for performing a specified list of functions. However, many decisions are left to the states.

1. Beyond the Exchange's minimum requirements, are there additional functions that should be considered for Connecticut's Exchange? Why?
   Not during the establishment of the exchange but these should be determined annually moving forward

2. Are there advantages to limiting the number of plans offered in the Exchange, or is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?
   Any willing provider who meets established criteria should be allowed to sell coverage through the exchange. This will ensure greater choice and access- but information that is provided will need to be standardized and specific to the various existing protections for consumers and physicians.

3. Should Connecticut consider setting any conditions for employer participation in the small group exchange (e.g. minimum percent of employees participating, minimum employer contribution, limits in the range of product benefit values that may be selected by employees, etc)?
   Employees should have the ability to choose coverage that is right for them and their families. Employers should not be prevented from participating should employees opt not to participate in a given plan or plan year. However, minimum employer contributions should be established so that there are proper incentives and disincentives associated with the exchange and its plan options.

4. What are some of the initiatives that could maximize flexibility and offer a value for small business employers to utilize the Exchange?
   Information and education are always critical pieces that could be provided that would encourage and enhance participation. In addition, wellness programs and incentives that may be built into the exchange structure, that provide some added service or benefit could be considered as either add on services offered directly by the exchange or through the plans.

5. What should be the role of the Exchange in premium collection and billing?
   None- billing for health insurance and health insurance claims administration is very complex and rather complicated as the number of plan options and the number of plan features and benefits expand. Unless there was some standardization of benefit collection and payment (electronic funds transfer requirements), it appears to be an overly burdensome engagement for the exchange, at least at the onset.

6. What are all the different data collection and reporting mechanisms that are necessary to operate a transparent and accountable Exchange?
   The plans involved in the exchange are going to have to provide enough patient de-identified and aggregate information on service utilization, cost, and payment to allow the exchange to track and then recommend changes to overall plan or benefit design. The plans are also going to have to be allowed to share this information in an open forum so that consumers and physicians and other health care providers and health care professionals, as well as the plans themselves, can compare and contrast their involvement (as plan participants, plan providers and exchange participants. The information is going to have to be made available in aggregate form, but also by plan and plan design for better comparison of plan options and benefit packages. Without transparent and shared information, the exchange will not be able to make informed decisions about its structure and exchange participants (the plans) and consumers will not be able to make choices that will expand choice and access to medical care.

The general information on each topic area below is intended for brief reference only.

A. Establish a Responsive and Efficient Structure

The ACA requires that all states establish an American Health Benefits Exchange for the individual market and a Small Business Health Options Program (SHOP Exchange) for the small group market. States may operate these independently or may combine them into a single Exchange. States may also form regional or multi-state Exchanges.

For the purpose of inclusion in the SHOP Exchange, the ACA defines small employers as an employer with 2-100 employees. However, until 2016, states may limit this definition to 2-50 employees; and after 2017 states may further expand participation in the SHOP Exchange.

B. Address Adverse Selection and the External Market

The ACA allows states to establish a "dual market" in which individual insurance may be purchased in and out of the Exchange, or to require that all health insurance plans sold on the individual market must be sold through the Exchange. States may also design "hybrid" solutions such as permitting supplemental coverage to be sold in external markets but requiring that all individual major medical coverage be sold in the Exchange.

The ACA establishes certain rules to protect against selection issues in a dual market, but does not deny states the ability to include additional requirements for insurance sold in the Exchange and an external market. State options include but are not limited to requiring that all insurers in the Exchange offer all four tiers of coverage, standardizing benefits packages, and restricting the sale of "catastrophic" insurance plans. However at a minimum, the following rules apply:

- Plans inside and outside of an Exchange must be in the same risk pool, have the same premium rate (for those sold by the same company), and meet the same minimum benefits standards.
- Insurers inside and outside the Exchange may not deny coverage on the basis of pre- existing conditions, medical status, or claims history.
- Premium variation based on age, geographic location, and smoking status must apply to plans sold both inside and outside the Exchange.
- Plans sold in the Exchange must have an open enrollment period and special enrollment periods to encourage participants to purchase coverage before they become sick.

The ACA requires that states establish a reinsurance program for the individual market inside and outside of the Exchange, for the first three years of Exchange operation. The NAIC will develop model legislation to carry out this provision. States must consider issues such as how to coordinate their high risk pools with this program.

C. Simplify Health Insurance Purchase

The ACA requires an Exchange to establish a "Navigator" program to conduct public education, advise individuals and small groups that enroll in the Exchange, help them enroll in health plan and access benefits, and provide referrals as needed to the health care ombudsman. The Navigator program must be established by awarding grants to a variety of groups, and must be financed through operational funds of the Exchange (not Federal funds received by the state to establish the Exchange).

With establishment of an Exchange, the existing relationship between brokers, carriers, and consumers is likely to change. The ACA leaves states flexibility to make decisions regarding these relationships, such as designating an official role for brokers within the Exchange apparatus, requiring certification, or regulating commissions.

D. Increase Access to and Portability of High Quality Health Insurance

The ACA requires that health plans that wish to participate in an Exchange (Qualified Health Plans) comply with certain requirements related to marketing, choice of providers, plan networks, and essential health benefits. Beyond this, states may establish additional requirements for plans that are offered on an Exchange.

The ACA provides states with the option of operating a Basic Health Program for individuals between 133% and 200% of the federal poverty level, in lieu of those individuals receiving premium subsidies for purchase of coverage. The benefits under the Basic Health Program must be at least equivalent to the essential health benefits and premiums may not be higher than those in the Exchanges.

With health care reform, individuals may be eligible for one of a variety of insurance options: Medicaid, CHIP, subsidized coverage through an insurance Exchange, and unsubsidized coverage through an Exchange. The ACA requires that there should be a single seamless process of applying for coverage for all of these programs – regardless of where a consumer enters the system.

E. Ensure Greater Accountability and Transparency

The ACA requires that Exchanges post information on the cost and quality of health plans. Specifically, states must develop an Internet website for standardized comparative information on plans, provide public ratings of participating Exchange plans, and use a standard format for presenting health plan options in the Exchange.

F. Self-Sustaining Financing

The ACA includes grant funding for planning and establishment of Exchanges, but beginning January 1, 2015, state Exchanges must be financially self-sustaining.

The ACA establishes a minimum essential benefit set to be sold inside and outside an Exchange. A state may choose to require additional benefits but must cover the cost of those benefits for individuals eligible for tax credits through an Exchange.

G. Under the ACA, an Exchange is responsible for performing a specified list of functions. However, many decisions are left to the states.

Under federal law, the Exchange is required to perform these functions:

- Certify, recertify, and decertify qualified health benefits plans under the guidelines established by the federal Department of Health and Human Services (HHS)
- Operate a toll-free customer assistance hotline
- Maintain a website that allows customers to compare qualified health benefits plans offered by different insurance carriers
- Assign a rating to each qualified health plan under the rating system that will be established by HHS
- Use a standardized format to present four coverage options (bronze, silver, gold, and platinum), plus the catastrophic plan design for young adults/exemptions
- Inform individuals about the existence of—and their eligibility for—public programs, including but not limited to Medicaid and Children's Health Insurance Program (CHIP)
- Certify individuals who are exempt from the individual mandate on the basis of hardship or other criteria to be established by HHS
- Transfer information to the federal Secretary of Treasury regarding individual mandate exemptions and subsidies awarded due to a failure on the part of a small employer to provide sufficient affordable coverage
- Provide information to employers on their employees who are not covered
- Establish a network of navigators to raise awareness among customers of their coverage options and to help people select and enroll in health plans and subsequently access benefits